MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

57 — 00575 — Reg. Dist. No.

1. PLACE OF DEATH — a. COUNTY: Charles — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) — a. STATE: Md. — b. COUNTY: Charles
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mason Springs — c. LENGTH OF STAY IN 1b: 41yrs
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mason Springs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
d. STREET ADDRESS: 1 RFD La Plata — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen — Middle: Daisy — Last: Ashton
4. DATE OF DEATH: Month: January — Day: 5 — Year: 1958
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 14, 1881
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Pisgah
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Queen
14. MOTHER'S MAIDEN NAME: Eliza Victoria Fridy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mabel E. Bowman — Address: Pisgah, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — Interval between onset and death: Immed.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1
DUE TO (b): Hypertensive Heart Disease — 4yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pernicious Anemia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank G. Susan M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Frank A. Susan M.D.
DATE SIGNED: 1/5/58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 9 1958
22c. NAME OF CEMETERY OR CREMATORY: St. Charles
22d. LOCATION (City, town, or county): Glymont, (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Huntt Fun. Home — ADDRESS: Waldorf, Md.
24a. REC'D BY REGISTRAR DATE: JAN 10 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the [illegible] prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00576

CERTIFICATE OF DEATH

580

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LaPlata
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Phy Mem Hospt

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Charles.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): + IronSides Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES Middle WATSON Last BROCK

4. DATE OF DEATH: Month 1 Day 11 Year 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH:

9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Semi retired Inspector

10b. KIND OF BUSINESS OR INDUSTRY: Lumberman

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: David Brock

14. MOTHER'S MAIDEN NAME: Custer Eagens.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address
Vlodys Brock Ironsides Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): COMMINUTED FRAC SKULL — INTERVAL BETWEEN ONSET AND DEATH: 1-11-58
824 x
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): AUTO ACCIDENT — 1-11-58

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Driver OF CAR WHICH SKIDDED & THREW HIM OUT

20c. TIME OF INJURY Hour: a. m. / p. m. Month 1 Day 11 Year 1958

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Hway

20f. (City or town) IRONSIDES (County) CHAS (State) Md.

21. I certify that I attended the deceased from MED EXAM & CASE, 19____, that I last saw the deceased alive on 1-11-58, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. Edelen M.D. ADDRESS (Street, city or town, state): LA PLATA MD DATE SIGNED: 1-11-58

PHYSICIAN'S NAME (Type): E. J. EDELEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1-14-58

22c. NAME OF CEMETERY OR CREMATORY: Roberts Cemetery

22d. LOCATION (City, town, or county) (State): Morton Va

23. FUNERAL DIRECTOR'S SIGNATURE: Herbert Inc ADDRESS: Laplata Md

24a. REC'D BY REGISTRAR DATE: JAN 14 '58

24b. REGISTRAR'S SIGNATURE: W. Leavitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG225 1-31-58 et

581

CERTIFICATE OF DEATH

Reg. Dist. No. 00577

1. PLACE OF DEATH
a. COUNTY: CHARLES MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WALDORF
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WALDORF
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LESTER Middle EDWARD Last CLARK

4. DATE OF DEATH: Month JAN Day 21 Year 1958

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG 21, 1883

9. AGE (In years last birthday): 74/5 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: EDWARD CLARK

14. MOTHER'S MAIDEN NAME: EULALIE BROWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 218 09 6767

17. INFORMANT: MRS Lottie A. CLARK Address: WALDORF, md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary Atherosclerosis — yrs
DUE TO
(c): Generalized Atherosclerosis — yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-14 19 58, to 1-21 19 58 that I last saw the deceased alive on 1-21 58 19, and that death occurred at 10:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert N Dobson M.D. ADDRESS (Street, city or town, state): Bowie, Md. DATE SIGNED

PHYSICIAN'S NAME (Type): Robert N Dobson MD Bowie Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 1-24-58

22c. NAME OF CEMETERY OR CREMATORY: ST Peter's Cem.

22d. LOCATION (City, town, or county) (State): WALDORF, md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hunt Funeral Home, ADDRESS: WALDORF, md.

24a. REC'D BY REGISTRAR DATE: JAN 27 '58

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

582

CERTIFICATE OF DEATH

00578

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LA PLATA
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PHYSICIANS' MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DENTSVILLE (RURAL)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): FIRST ELIZABETH MIDDLE MARY Last COOKSEY

4. DATE OF DEATH: Month JANUARY Day 19 Year 1958

5. SEX: FEMALE

6. COLOR OR RACE: WHITE-US

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: SEPTEMBER 12, 1875

9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: WILLIAM H. CRESMOND

14. MOTHER'S MAIDEN NAME: MARY ANNA ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT Address: WILLIAM ELMER COOKSEY; DENTSVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	ARTERIO SCLEROTIC HEART DISEASE (CORONARY)	6 DAYS
DUE TO	INSUFFICIENCY)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	ARTERIO SCLEROSIS WITH HYPERTENSION	15 YEARS
DUE TO (c)	DIABETES MELLITUS (MILD)	4 YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 260 X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JANUARY, 1950, to JANUARY 19, 1958 that I last saw the deceased alive on JANUARY 19, 1958, and that death occurred at 7:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John H. Griffin M.D. — ADDRESS (Street, city or town, state): Hughesville, Md. — DATE SIGNED: 1/20/58

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 1-22-58 — 22c. NAME OF CEMETERY OR CREMATORY: ST MARYS CEM — 22d. LOCATION (City, town, or county) (State): NEWport, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hunt Funeral Home — ADDRESS: WALDORF, Md.

24a. REC'D BY REGISTRAR DATE: JAN 23 '58 — 24b. REGISTRAR'S SIGNATURE: Outwaite

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

583

CERTIFICATE OF DEATH

Reg. Dist. No. 00579

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Plata,
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Physicians Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brandywine, Md. Route 1 Box 60 16X-2
d. STREET ADDRESS: ---
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First [redacted]x Middle Owen Lost Grimes
4. DATE OF DEATH: Month January Day 18 Year 1958
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Aug. 23, 1891 ~~Date 23 1889~~
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tobacco Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm ~~[redacted]xxxxxxxxxx~~
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry W. Grimes
14. MOTHER'S MAIDEN NAME: Sarah M. Hyde

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: +
17. INFORMANT: Pearl Grimes - Address: Rt. #1, Box 60, Brandywine, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro-Vas. Accident — INTERVAL BETWEEN ONSET AND DEATH: 1-16-58
331X
DUE TO (b): Hypertension — ??
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-16 58 to 1-18 19 58 that I last saw the deceased alive on 1-18 58, and that death occurred at 10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. J. Edelen M.D. ADDRESS (Street, city or town, state): LAPLATA DATE SIGNED: 1-19-58
PHYSICIAN'S NAME (Type): E. J. EDELEN MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/22/58
22c. NAME OF CEMETERY OR CREMATORY: Cedarville Cemetery
22d. LOCATION (City, town, or county) (State): Cedarville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ritchie Bros. Funeral Home — ADDRESS: Upper Marlboro, Md.
24a. REC'D BY REGISTRAR DATE: JAN 27 '58
24b. REGISTRAR'S SIGNATURE: W. Leavitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

584 **CERTIFICATE OF DEATH** 00580

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Charles — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Victoria

c. LENGTH OF STAY IN 1b:

d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institutions: Res dence before admission)
a. STATE: Maryland — b. COUNTY: Charles

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Mt. Victoria

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Frank — Middle: — Last: Hemsley

4. DATE OF DEATH: Month: 1 — Day: 7 — Year: 1958

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-7-1878

9. AGE (In years last birthday): 79 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Hemsley

14. MOTHER'S MAIDEN NAME: Mary ?

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16 SOCIAL SECURITY NO: none

17 INFORMANT — Address: Eddie Hemsley Mt Victoria, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1955

4-7-58

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertension — 1955

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 3-28-'55, 19__, to 1-7, 1958, that I last saw the deceased alive on Nov. 9, 1957, and that death occurred at 3 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. J. Edelen M.D — ADDRESS (Street, city or town, state): La Plata, Md. — DATE SIGNED: 1-10-'58

PHYSICIAN'S NAME (Type): E. J. Edelen, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: 1-11-58

22c. NAME OF CEMETERY OR CREMATORY: Holy Ghost Cem.

22d LOCATION (City, town, or county) (State): Issue, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Huntt Funeral Home Waldorf, Md.

24a REC'D BY REGISTRAR DATE: JAN 13 '58

24b REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

585 Tte. 2-7-58 at

CERTIFICATE OF DEATH

Reg. Dist. No. 00581

1 PLACE OF DEATH
a. COUNTY Charles MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Charles

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X White Plains

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First EDWARD Middle LAYTON Last JOHNSON

4. DATE OF DEATH Month Jan Day 28 Year 1958

5. SEX M

6. COLOR OR RACE N

7 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH Feb 29, 1888

9 AGE (In years last birthday) 69Y yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Henry Johnson

14. MOTHER'S MAIDEN NAME Martha Humphrey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT Address Charlotte Johnson, White Plains, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-Sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Indefinite

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Arterial Hypertension — Indefinite

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-10-54, 19—, to 1-28-58, 19—, that I last saw the deceased alive on 1-28-58, 19—, and that death occurred at 4:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE James E. Andrews M.D. ADDRESS (Street, city or town, state) 17-Potomac Ave Indian Head Md. DATE SIGNED 1-28-58

PHYSICIAN'S NAME (Type) James E. Andrews MD

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 1-31-58

22c. NAME OF CEMETERY OR CREMATORY ST PAULS Cemetery

22d. LOCATION (City, town, or county) WALDORF (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS The Huntt Funeral Home Waldorf, Md.

24a. REC'D BY REGISTRAR DATE FEB 3 58

24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

586 **CERTIFICATE OF DEATH** 00582

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Charles MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata
c. LENGTH OF STAY IN 1b
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Phy Mem. Hosp.

2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE Maryland b. COUNTY Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~La Plata~~ Bryantown
d STREET ADDRESS —
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3 NAME OF DECEASED (Type or print) First HARRY Middle J. Last JOHNSON
4. DATE OF DEATH Month JAN. Day 4 Year 1958

5 SEX MALE
6. COLOR OR RACE Col
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH Feb 27, 1876
9. AGE (In years last birthday) 81 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME Joseph Johnson
14 MOTHER'S MAIDEN NAME Bonnie Penn

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO —
17 INFORMANT Address Adrian Johnson Bryantown Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition and Terminal Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 2 weeks

DUE TO (b) Cerebrovascular Hemorrhage — 4½ mo.

DUE TO (c) Primary Arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) No injury
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Dec. 4, 1951, to 4 JAN., 1958, that I last saw the deceased alive on 4 JAN, 1958, and that death occurred at 2:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Vernon B Dettor M.D. ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 1-6-58

PHYSICIAN'S NAME (Type) VERNON B. DETTOR

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF 1/6/58
22c. NAME OF CEMETERY OR CREMATORY St Mary's
22d. LOCATION (City, town, or county) (State) Bryantown Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Lee Hewitt Funeral Home Waldorf Md.
24a. REC'D BY REGISTRAR DATE JAN 9
24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Fi n G224, 1/21/58 fcv 587

CERTIFICATE OF DEATH

Reg. Dist. No. 00583

1. PLACE OF DEATH
a. COUNTY: CHARLES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): POMONKEY
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Md — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): POMONKEY
d STREET ADDRESS: RFD LA PLATA md.
e IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First FRANK Middle Last LITTLE
4. DATE OF DEATH: Month JAN Day 13 Year 1958

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Aug 5, 1884
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): [redacted] KY.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: William Little
14. MOTHER'S MAIDEN NAME: MARY H. WOOTEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 302 16 0116
17. INFORMANT: MARY H. KNAPP Address RFD LA PLATA, md. POMONKEY, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 1 WK
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JAN 6, 1958, to JAN 13, 1958, that I last saw the deceased alive on JAN 13, 1958, and that death occurred at 10:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank G. Susan M.D. — ADDRESS (Street, city or town, state): Indian Head, md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): DR FRANK SUSAN

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
22b. DATE THEREOF: 1-14-1958
22c. NAME OF CEMETERY OR CREMATORY: IRONTOWN, OHIO CEM.
22d LOCATION (City, town, or county) (State): IRONTOWN Ohio

23. FUNERAL DIRECTOR'S SIGNATURE: Hunt Funeral Home — ADDRESS: WALDORF, md.
24a. REC'D BY REGISTRAR DATE: JAN 1 5 '58
24b. REGISTRAR'S SIGNATURE: C.W. COLLINS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

588 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00584
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Items 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mason Springs
c. LENGTH OF STAY IN 1b: 4 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RFD La Plata

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mason Springs
d. STREET ADDRESS: RFD La Plata
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle Samuel — Last Maddox
4. DATE OF DEATH: Month January — Day 31 — Year 1958
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 7, 1957
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months 3 Days 24 — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mason Springs. Md
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME: William Thomas Maddox
14. MOTHER'S MAIDEN NAME: Dolores Elizabeth Montgomery
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Tracheo-Bronchitis death Primary — INTERVAL BETWEEN ONSET AND DEATH: 1 day
500 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank A Susan M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 1-31-58
EXAMINER'S NAME (Type): Frank A. Susan M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 3, 1958
22c. NAME OF CEMETERY OR CREMATORY: St. Charles
22d. LOCATION (City, town, or county) (State): Indian Head Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hewitt Funeral Home, Waldorf Md.
24a. REC'D BY REGISTRAR DATE: FEB 5 '58
24b. REGISTRAR'S SIGNATURE: Witness

VS. A15ME(5)
5M 9/55

4000192-XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00585

Reg. Dist. No. 589

1. PLACE OF DEATH
a. COUNTY Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fair Hill Md
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mem Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md — b. COUNTY Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: SIDLER Middle: MAYNARD E Last:
4. DATE OF DEATH Month: 1 Day: 26 Year: 1958
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 7-4-1909
9. AGE (In years last birthday) 48 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NAA Powder Factory
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pisgah Miss
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George W Sidler
14. MOTHER'S MAIDEN NAME Sarah J Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-03-1611
17. INFORMANT Address: Mrs Horace Sidler Jr Perryville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock & Hemorrhage of
DUE TO (b) Spinal Cord
DUE TO (c) Auto accident
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: (a) 1-22-58 (b) 1-22-58

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Car crashed into Tree
20c. TIME OF INJURY Hour: 7 a.m. p.m. Month, Day, Year: 1-22 19 58
20d. INJURY OCCURRED While at work ☐ Not while at work ☑
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway
20f. (City or town) (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE C. Medlen M.D.
EXAMINER'S NAME (Type) W. T. EDELEN
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED 1-27-58

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1-28-58
22c. NAME OF CEMETERY OR CREMATORY Manjamoy Baptist
22d. LOCATION (City, town, or county) (State) Manjamoy Md

23. FUNERAL DIRECTOR'S SIGNATURE Orehart Inc
ADDRESS Laplata Md.
24a. REC'D BY REGISTRAR DATE JAN 29 '58
24b. REGISTRAR'S SIGNATURE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the [illegible] or prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
$M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

59 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00586

1. PLACE OF DEATH — a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Waldorf
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Alton
e. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JAMES Middle Lee Last THOMPSON
4. DATE OF DEATH: Month 1 Day 3 Year 58

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 6, 1899
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farm Labor
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Leroy Thompson
14. MOTHER'S MAIDEN NAME: Mary Winder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or defferal service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Rena Thompson — Address: Bel Alton, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 1-2-58
420.1
DUE TO (b): CORONARY HEART DISEASE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. J. Edelen — M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☑ — DATE SIGNED
EXAMINER'S NAME (Type): E. J. EDELEN — 1-3-58

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Jan. 6 1958
22c. NAME OF CEMETERY OR CREMATORY: St Ignatius
22d. LOCATION (City, town, or county) (State): Bel Alton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hunt Fun. Home — ADDRESS: Waldorf, Md.
24a. REC'D BY REGISTRAR — DATE: JAN 7 '58
24b. REGISTRAR'S SIGNATURE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

591 00587
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Charles — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dentsville
c. LENGTH OF STAY IN 1b: 6 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Md. — b. COUNTY: CHARLES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x DENTSVILLE,
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First SALLY Middle ANNE Last WATSON
4. DATE OF DEATH: Month 1 Day 17 Year 1958
5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6-10-1878
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Richard Adams.
14. MOTHER'S MAIDEN NAME: Jane McKay??

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Julyone Watson — Address: Newburg Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1-17-58
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertension — 7
DUE TO (c): — 1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour ☐ a.m. ☐ p.m. — Month, Day, Year: 1-17 1958
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: E. J. Edelen — M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): E. J. EDELEN
DATE SIGNED: 1-17-58

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 1-20-58
22c. NAME OF CEMETERY OR CREMATORY: St Peter's Com.
22d. LOCATION (City, town, or county) (State): WALDORF Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hunter Funeral Home — ADDRESS: Waldorf, Md.
24a. REC'D BY REGISTRAR DATE: JAN 21 '58
24b. REGISTRAR'S SIGNATURE: W. Leach

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the record prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55